MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02276 — 02272

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires thot the death certificate be executed within 24 hours after death. Page 4 moy be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M - 1X69

1. DECEASED-NAME (Type or print)	First: PAUL	Middle: JAMES	Last: ARNDT	2a. DATE OF DEATH: Month February Day 7 Year 1969	2b. HOUR: 6:25 P.M.	
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: 10-21-46	6. AGE (In years last birthday): 22 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	
7a. BIRTHPLACE (State or foreign country): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Cecil Md.			
10. CITY OR TOWN OF DEATH: Perry Point	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street oddress): Veterans Administration	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Chemical Technician	12b. KIND OF BUSINESS OR INDUSTRY: Chem. Plant			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md	13b. COUNTY: Harford	13c. CITY OR TOWN: Aberdeen	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 629 Walker Street		
14. FATHER'S NAME First Middle Last: Paul W. Arndt	15. MOTHER'S MAIDEN NAME First Middle Last: Lucille J. Albano					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: yes (If yes give war or dates of service): PL-90	16b. SOCIAL SECURITY NO.: 215-48-3971	17. INFORMANT Address: VA Records, VAH, Perry Point, Md.				

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Malignant Cachexia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last. 1737

(b) Sarcoma of left upper arm with generalized metastasis — 15 Months

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☒ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol exominer)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While ot work ☐ Not while ot work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County Stote

22a. **I certify** that (I) (this hospital) attended the deceased from 1-31, 1969, to 2-7-, 1969, that (I) (we) last saw the deceased alive an 2-7-69 19___, and that in (my) (aur) apinian death accurred an the date and haur and fram the causes stated abave, (I) (we) (did) (did nat) view the bady after death.

22b. SIGNATURE: A. L. Mooney, M.D. DEGREE — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒ — 22c. DATE SIGNED: 2-8-69

22d. PHYSICIAN'S NAME (Type): A. L. MOONEY, M.D. — 22e. ADDRESS: VAH, Perry Point, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 12-Feb.1969	23c. NAME OF CEMETERY OR CREMATORY: Harford Memorial Gardens	23d. LOCATION (City or Town) (County) (State): Aberdeen, (Harford) Maryland

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
JOHN G TARRING 333 S.Parke St Aberdeen,Md	FEB 10 1969	Circuit Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02277 02273

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First / Middle / Lost	George Edward Atkinson	2a. DATE OF DEATH Month / Day / Year	Feb. 25 1969
2b. HOUR	1030 P.M.		
3. SEX	Male	4. RACE	White
5. DATE OF BIRTH	April 5, 1893	6. AGE (In years lost birthday)	75 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS		IF UNDER 24 HRS.: HOURS / MIN	
7a. BIRTHPLACE (State or foreign country)	Maryland	7b. CITIZEN OF WHAT COUNTRY?	USA
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED XX DIVORCED ☐		9. COUNTY OF DEATH	Cecil Md.
10. CITY OR TOWN OF DEATH	Elkton	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street oddress)	Union Hospital
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	Herdsman	12b. KIND OF BUSINESS OR INDUSTRY	Farming
13a. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) STATE	Maryland	13b. COUNTY	Cecil
13c. CITY OR TOWN	North East	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	
13e. STREET AND NUMBER	R.D. # 1		
14. FATHER'S NAME First / Middle / Lost	William T. Atkinson	15. MOTHER'S MAIDEN NAME First / Middle / Lost	Bertha Rutter
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	No	16b. SOCIAL SECURITY NO.	
17. INFORMANT / Address	Mrs. Mary C. Rawson		Newark, Del.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) BRAIN DAMAGE - ANOXIA — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

DUE TO, OR AS A CONSEQUENCE OF

(b) CEREBROVASCULAR ACCIDENT — 2 weeks

DUE TO, OR AS A CONSEQUENCE OF

(c) GENERALIZED ARTERIOSCLEROSIS — ? Years

4369

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

BENIGN PROSTATIC HYPERTROPHY - SUPRAPUBIC PROSTATECTOMY - 2-13-69

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES ☐ NO ☒		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol exominer)		21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	
21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)			
21d. INJURY OCCURRED While at work ☐ Not while at work ☐		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	
21f. LOCATION Street or R.F.D. No. / City or Town / County / Stote			

22a. **I certify** that (I) (this hospital) attended the deceased from 2-4, 1969, to 2-25, 1969, that (I) (we) last saw the deceased alive on 2-25 1969, and thot in (my) (our) opinion death occurred on the dote and hour and from the causes stated obave, (I) (we) (did) (did not) view the bady ofter death.

22b. SIGNATURE	Rolando A. Najera M.D.	DEGREE ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED 2-26-69
22d. PHYSICIAN'S NAME (Type)	Rolando A. Najera	22e. ADDRESS	105 E. Main St. Elkton, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	Burial	23b. DATE	2-28-69	
23c. NAME OF CEMETERY OR CREMATORY	St. Marks Cemetery	23d. LOCATION (City or Town) (County) (Stote)	Perryville Cecil Md.	
24. FUNERAL DIRECTOR	Grant Funeral Home	ADDRESS	North East, Md.	
25a. RECD BY REGISTRAR DATE	FEB 28 1969	25b. REGISTRAR'S SIGNATURE	Charles Judge	

VR A15 (1) 45M - 1/69

Items 21&22a Film 409
2-24-69 ams

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02278 02274

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR	
Clara	R.	Benjamin	Feb. 10, 1969	M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN
Female	Cau.	November 14, 1877	91 YRS.		
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH		
Maryland	USA		Cecil Md.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY		
Rising Sun	10 Walnut Street	House Wife	———		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER	
Maryland	Cecil	Port Deposit	YES ☐ NO ☒	R.F.D. # 1	
14. FATHER'S NAME First / Middle / Last		15. MOTHER'S MAIDEN NAME First / Middle / Last			
Thomas Miller Jackson		Maria Dennison			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address			
No ———	215-54-2547	Elsie B. Kennard, Rising Sun, Maryland.			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

Conditions, if any, which gave rise to immediate couse (a), stoting the underlying cause lost.

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Fractured skull	20 minutes
DUE TO, OR AS A CONSEQUENCE OF (b)	arteriosclerosis cerebral	5 yrs.
DUE TO, OR AS A CONSEQUENCE OF (c)		

880 X

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☐	

21a. ACCIDENT WAS UNDERLYING	21b. TIME OF INJURY	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)
☒ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol examiner)	HOUR A.M. P.M. Month Day Year 10 AM 2 10 1969	Fell down stairs

21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State
While at work ☐ Not while at work ☒	Home	Walnut St. / Rising Sun / Cecil / Md.

22a. **I certify** that (I) (this hospital) attended the deceased from 6-10, 1955, to 2-10, 1969, that (I) (we) last saw the deceased alive on 6-10 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated obove, (I) (we) (did) (did not) view the body after death. Accident

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Neil R. Taylor	ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	2-10-69
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS
Neil R. Taylor Jr. M.D.		17 Haines Ave., Rising Sun, Maryland.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	2/13/1969	Hopewell Cemetery	Port Deposit Cecil Md.

24. FUNERAL DIRECTOR ADDRESS	25a. RECEIVED BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Lee A. Patterson & Son, Perryville, Md.	FEB 14 1969	

VR A15 (1)
45M - 1/68

1

FOR STATE HEALTH DEPT.

Items7&8 FilmG410 3/5/69kk

Items 18-22aFilm411 4-16-69ams

02275

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02275

1. DECEASED-NAME (Type or Print) First	Middle	Last
CLARA	B.	BLACKSTON

2a. DATE KNOWN OF DEATH [X] ESTIMATED [ ] Month 2 Day 18 Year 1969 — 2b. HOUR 11:47a

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS	DAYS	IF UNDER 24 HRS.: HOURS	MIN
Female	Colored		38 YRS.				

2c. DATE PRONOUNCED DEAD Month February Day 18 Year 1969 — 2d. HOUR 11:47a

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH
Delaware	USA		Cecil Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of work done during mast of warking life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Elkton	Union Hospital		

13a. USUAL RESIDENCE (Where deceased lived, if institutin: Residence before odmission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Del.		Middleton	YES [ ] NO [ ]	412 N. Cox St.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Walter		Bordley	Ella		Bordley

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
	221-18-6883	Harry H. Blackston-Middletown, Del.	412 N.Cox St.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiovascular collapse during

DUE TO, OR AS A CONSEQUENCE OF

(b) anesthesia for abdominal hysterectomy

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditians, if any, which gove rise to immediote cause (a). stating the underlying couse last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
2/18/69	Abdominal hysterectomy	YES [XX] NO [ ]

21a. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. ? P.M. 2-18 19 69	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
		Above

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]	21e. PLACE OF INJURY (At home, farm, street, factary, affice building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
	Hospital	Union Hospital		Cecil	Md.

22a. **I certify** that I took charge of the remains described above, held an Autapsy [XX] Inspection [ ], Inquiry [ ], and in my opinion death resulted from: Natural causes [ ], Accident [X], Suicide [ ], Hamicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE Edward F. Wilson M.D.

EXAMINER'S NAME (Type) Edward F. Wilson, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ZZ]
DEPUTY MEDICAL EXAMINER [ ]
ADDRESS(Street, city, town, or county)

22b. DATE SIGNED 2/19/69

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	2/22/69	Dale Cemetery	Middletown, Del.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Calvin R. Bell	909 Poplar St.	FEB 26 1969	Florence Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 10M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02280 — 02276

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
Calvin	W	Butler	February	22,	1969	5:25 a.m.

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS HOURS	MIN
Male	White	August 25, 1896	72 YRS.				

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9. COUNTY OF DEATH
Easton, Md	U.S.A.		CECIL Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Perry Point	VA HOSPITAL	R.R. Brakeman	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
VIRGINIA		Cape Charles	YES ☒ NO ☐	525 Monroe Avenue

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Frank Butler			Laura Etta Butler		

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
Yes WW I	217-54-7556	VA HOSPITAL RECORDS, Perry Point, Maryland

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Bacterial Septicemia and Toxemia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO, OR AS A CONSEQUENCE OF

(b) Pyelonephritis and cystitis

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 5901

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
	VA				

22a. **I certify** that (I) (this hospital) attended the deceased from Oct. 16, 19 28, to Feb. 22, 19 69 [illegible] and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
[signature]	M.D.	☐	☐	☒	2-22-69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
RUSSELL E. MORRIS, JR.	VA HOSPITAL, Perry Point, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Removal	2-22-69	Greensboro Cemetery	Greensboro, Md

24. FUNERAL DIRECTOR	ADDRESS	25a. REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Rawlings-Boulais	Greensboro, Md.	FEB 27 1969	[signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1-69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02281 — 02277

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
Ralph	William	Carr Sr.	Feb	25	1969	3P M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
Male	White	Jan. 1, 1911	58 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9. COUNTY OF DEATH
Md.	U.S.A.		Cecil Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Conowingo R.F.D.	Conowingo R.F.D.	Laborer	Stone Quarry

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET AND NUMBER
Md.	Cecil	Conowingo		R. F. D.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
William	Pussey	Carr			Harman

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT (Son)	Address
No		218-05-9402	Ralph W. Carr Jr.	Same as Above

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Myocardial Infartion — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO, OR AS A CONSEQUENCE OF

(b) Two previous infarctions in two months

DUE TO, OR AS A CONSEQUENCE OF

(c) Arteriosclerotic heart disease — 5 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 11-1, 1968, to 2-25, 1969, that (I) (we) last saw the deceased alive on 2-25 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS. ☒	MED. DIRECTOR ☐	STAFF PHYS. ☐	22c. DATE SIGNED
Neil R Taylor					2-27-69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Neil R. Taylor Jr.	Rising Sun, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)	24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Burial	2-28-1969	Pleasant Groove Cem.	Peachbottem Lancaster PA.	Jerome McMullen	Rising Sun, Md.	MAR 3 1969	Charles Jones

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02282 02278

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First: WILLIAM	Middle: THOMAS	Last: COLLINS	2a. DATE OF DEATH Month: Feb	Day: 3	Year: 1969
2b. HOUR: 9:00 AM					
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH: OCT. 26, 1881	6. AGE (In years last birthday): 87 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN
7a. BIRTHPLACE (State or foreign country): CECIL Md.	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: CECIL Md.		
10. CITY OR TOWN OF DEATH: ELKTON	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): UNION HOSP	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): MACHINIST	12b. KIND OF BUSINESS OR INDUSTRY: TOOL & DYE		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md	13b. COUNTY: CECIL	13c. CITY OR TOWN: ELKTON	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 142 W. HIGH ST.	
14. FATHER'S NAME First: WILLIAM	Middle: V.	Last: COLLINS	15. MOTHER'S MAIDEN NAME First: AMANDA	Middle: WRIGHT	Last:
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 183-12-0885	17. INFORMANT: MRS. ANNE C. TELASCO	Address: HICKSVILLE L.I., N.Y.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Squamous Cell Carcinoma, Skin, Neck — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 year

DUE TO, OR AS A CONSEQUENCE OF: With Metastases

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) DUE TO, OR AS A CONSEQUENCE OF

(c)

1734

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County / State

22a. **I certify** that (I) (this hospital) attended the deceased from 12/25/68, 19 69, to 2/3, 19 69, that (I) (we) last saw the deceased alive on 2/3 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: John A. Fischer	DEGREE: ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED: 2/5/69	
22d. PHYSICIAN'S NAME (Type): JOHN A. FISCHER	22e. ADDRESS: ELKTON, Md.		

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL	23b. DATE: FEB. 6, 1969	23c. NAME OF CEMETERY OR CREMATORY: ELKTON CEM.	23d. LOCATION (City or Town) (County) (State): ELKTON CECIL Md.	
24. FUNERAL DIRECTOR: PIPPIN FUNERAL HOME	ADDRESS: ELKTON Md.	25a. REC'D BY REGISTRAR DATE: FEB 7 1969	25b. REGISTRAR'S SIGNATURE: Charles Judge	

VR A15 45M - 1/68

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02283 02279

CERTIFICATE OF DEATH

1. **PLACE OF DEATH**
   a. COUNTY: CECIL — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ELKTON
   c. LENGTH OF STAY IN 1b: 5 WEEKS
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): UNION HOSPITAL

2. **USUAL RESIDENCE** (Where deceosed lived, if institution: Residence before admission)
   a. STATE: MARYLAND — b. COUNTY: KENT
   c. CITY OR TOWN (If outside corporote limits, write RURAL ond give neorest town): KENNEDYVILLE
   d. STREET ADDRESS: —
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First CLARA — Middle T. — Lost COPPER

4. **DATE OF DEATH**: Month FEB. — Doy 4, — Year 1969

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: NOV. 9, 1886

9. AGE (In yeors last birthday): 82 yrs.

IF UNDER 1 YEAR: Months — Doys — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: HOME

11. BIRTHPLACE (County & State, or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ALEXANDER THAWLEY

14. MOTHER'S MAIDEN NAME: VIRGINIA STOREY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes give wor or dotes of service): —

16. SOCIAL SECURITY NO.: 217-12-4034

17. **INFORMANT**: WARREN COPPER — Address: KENNEDYVILLE, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): LEFT HEMIPLEGIA — INTERVAL BETWEEN ONSET AND DEATH: 24 hours
DUE TO (b): C.V.A. — 24 hours
Conditions, if ony, which gove rise to immediote couse (o), stating the underlying couse last. DUE TO (c): —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): METASTASIS CARCINOMA OF GALL BLADDER & GENERALIZED

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1/27, 1969 to 2/4, 1969 that (I) (we) last saw the deceased alive on 2/3 1969, and that death accurred at 7:34 A.M. from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): HENRY U. DAVIS MD

22d. ADDRESS: CHESAPEAKE CITY MD

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 2-7-69

23c. NAME OF CEMETERY OR CREMATORY: CHURCHILL CEMETERY

23d. LOCATION (City or Town) (County) (State): CHURCH HILL KENT MD.

24. FUNERAL DIRECTOR: VICTOR N. KENNEDY — ADDRESS: STILLPOND, MD.

25a. REC'D BY REGISTRAR DATE: FEB 7 1969

25b. REGISTRAR'S SIGNATURE: [signature]

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02284

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02280

1. PLACE OF DEATH
a. COUNTY: Cecil
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Conowingo
c. LENGTH OF STAY IN 1b: 6 years
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Rock Springs Rd.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Conowingo
d. STREET ADDRESS: Rock Springs Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Robert; Middle Hayward; Last Crouse

4. DATE OF DEATH: Month February; Day 21; Year 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: May 27,1903

9. AGE (In years last birthday): 65 yrs. IF UNDER 1 YEAR: Months; Days. IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Sparta,N.C.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Hillary Crouse

14. MOTHER'S MAIDEN NAME: Lula Mabe

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 219-01-0453

17. INFORMANT Address: Mrs. Lula Ensign,Conowingo,Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Anoxia — INTERVAL BETWEEN ONSET AND DEATH:
485 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Cardio-Respiratory Failure — 3 days
DUE TO (c): Bronchopneumonia — 7 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour 6:30 a.m. p.m. 2/21/69

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town) (County) (State): Conowingo Cecil Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Rolando A. Najera M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22. DATE SIGNED: Feb.22,1969

EXAMINER'S NAME (Type): Rolando A. Najera, M.D.

Address (Street, city, town, or county)

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Feb.24,1969

23c. NAME OF CEMETERY OR CREMATORY: Conowingo Baptist

23d. LOCATION (City, town or county) (State): Conowingo Cecil Md.

24. FUNERAL DIRECTOR ADDRESS: JOHN H. HARKINS Delta,Penna.

25a. REC'D BY REGISTRAR DATE: MAR 3 1969

25b. REGISTRAR'S SIGNATURE: Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1SME (5)
5M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02285 02281

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 20 M 1/66

1. PLACE OF DEATH a. COUNTY: Cecil — MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton c. LENGTH OF STAY IN 1b: d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Union Hospital	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: Md. — b. COUNTY: Cecil c. CITY OR TOWN (If outside corporote limits, write RURAL and give neorest town): Chesapeake City d. STREET ADDRESS: e. IS RESIDENCE ON A FARM? YES ☐ NO ☒
3. NAME OF DECEASED (Type or print): First Charles — Middle Franklin — Last Dixon	4. DATE OF DEATH: Month February — Day 10, — Year 19 69
5. SEX: Male	6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH: February, 4, 1891
9. AGE (In yeors last birthday): 78 yrs.	IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Haurs / Min.
10a. USUAL OCCUPATION (Give kind of wark done during mast of warking life, even if retired): Ret. Farmer	10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (County & State, or fareign country): Earleville, Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Joseph Dixon.	14. MOTHER'S MAIDEN NAME: Jane Williams
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No. (If yes give war or dates of service)	16. SOCIAL SECURITY NO.: 218-40-1032-A
17. INFORMANT: Mrs. Susan DuBois, Stanton, Del.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CORONARY THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH: 15 MIN
DUE TO (b): ATRIAL FIBRILLATION — 4 YEARS
DUE TO (c): CHRONIC CARDIOVASCULAR RENAL DISEASE — SEVERAL YEARS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4100

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): UREMIA - PROSTATIC OBSTRUCTION

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19

20d. INJURY OCCURRED While at wark ☐ Not While at wark ☐

20e. PLACE OF INJURY (Home, farm, factary, street, affice bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from FEB 5, 19 69 to FEB 10, 19 69, that (I) (we) last saw the deceased alive on FEB 10 19 69, and that death occurred at 12 M, from causes and on the date stated above.

22a. SIGNATURE: H. J. Davis — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2/11/69

22c. PHYSICIAN'S NAME (Type): HENRY J. DAVIS MD

22d. ADDRESS: CHESAPEAKE CITY MD

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Feb. 13, 1969	Olivet Meth. Church Yard.	Galena, Kent, Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Edward Fellows & Son,	Millington, Md. 21651	FEB 14 1969	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02286 02282

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
Wilbur	Roy	Forney	Feb. 13 1969	3 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
Male	White	May 15, 1885	83 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Penn.	U.S.A.		Cecil Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Rising Sun, Md.	Calvert Mannor Nursing Home	Electrician	U.S.Navy

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md.	Cecil	Rising Sun	YES ☒ NO ☐	Cherry Street

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Jacob	—	Forney	Margaret	—	Knell

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
No	---	201-16-3129	Mrs Walter Cameron Rising Sun, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cerebrovascular accident — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 4 days

DUE TO, OR AS A CONSEQUENCE OF (b) Generalized atherosclerosis — 3 yrs

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4369

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 6-6, 1962, to 2-13, 1969, that (I) (we) last saw the deceased alive on 2-12 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Neil R. Taylor Jr.		☒	☐	☐	2-14-69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Neil R. Taylor Jr. M.D.	Rising Sun, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	2--15--69	Brookview Cem.	Rising Sun Cecil Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Simon E. McMullen Jr.	Rising Sun, Md.	FEB 17 1969	Thomas Judge

VR A15 (4) 30M REV. 1-68

1

02287

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02283

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

1. DECEASED-NAME (Type or print) First: Edna	Middle: Hannah	Last: Freeman	2a. DATE OF DEATH Month: Feb. Day: 16 Year: 1969		2b. HOUR: 4:40 P.M.
3. SEX: Female	4. RACE: negro	5. DATE OF BIRTH: June 14, 1906	6. AGE (In years last birthday): 62 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
7a. BIRTHPLACE (State or foreign country): Coatesville, Pa.	7b. CITIZEN OF WHAT COUNTRY?: United States	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Cecil Md.		
10. CITY OR TOWN OF DEATH: Port Deposit	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Box 118 Route 1 Port Deposit	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): House wife	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Port Deposit	13b. COUNTY: Cecil	13c. CITY OR TOWN: Port Deposit	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET AND NUMBER: Box 118 Route 1	
14. FATHER'S NAME First: Marshall	Middle: Pernsley	Last	15. MOTHER'S MAIDEN NAME First: Sarah	Middle: Rosetta	Last: Pernsley
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown): No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: None	17. INFORMANT: Rev St Paul Freeman	Address: Port Deposit Md		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral accident — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO, OR AS A CONSEQUENCE OF (b): Arteria Sclerosis, Hypertension — 3 yrs
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4360

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Myocarditis, Diabetes

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from July 5, 1967, to Feb 16, 1969, that (I) (we) last saw the deceased alive on Feb 16 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE				22c. DATE SIGNED
Clarence L. Benson MD	ATTENDING PHYS. ☒	MED. DIRECTOR ☐	STAFF PHYS. ☐		2/15/69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
CLARENCE L. BENSON	Port Depost, Md

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town)	(County)	(State)
Burial	2-25-69	Chestnut Grove Amk	Chester		PA

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
George W Tittle	Bel Air Md	FEB 27 1969	J Charles Judge

4 1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02288 02284

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First: Amanda	Middle: -------	Last: Gambill	2a. DATE OF DEATH Month: Feb. Day: 24 Year: 1969	2b. HOUR: 12:30 P.M.	
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH: 9--15--1891	6. AGE (In years last birthday): 77 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country): N.C.	7b. CITIZEN OF WHAT COUNTRY?: U. S. A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: Cecil Md.		
10. CITY OR TOWN OF DEATH: North East R.D.	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): North East R. D.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife Ret.	12b. KIND OF BUSINESS OR INDUSTRY: Own Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.	13b. COUNTY: Cecil	13c. CITY OR TOWN: N. East R.D.	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET AND NUMBER: North East R.F.D.	
14. FATHER'S NAME First: William	Middle: -----	Last: Brooks	15. MOTHER'S MAIDEN NAME First: Sally	Middle: --------	Last: Baugess
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT: Dean Gambill	Address: North East, R.F.D.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Heart Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 months
DUE TO, OR AS A CONSEQUENCE OF
(b):
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4270

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a): Diabetes

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. **I certify** that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: F.B. Robinson M.D. DEGREE	ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED: Feb 26 69	
22d. PHYSICIAN'S NAME (Type): F.B. Robinson M.D.	22e. ADDRESS: Oxford Pa		

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 2-27-1969	23c. NAME OF CEMETERY OR CREMATORY: Conowingo Baptist	23d. LOCATION (City or Town): Conowingo	(County): Cecil (State): Md.
24. FUNERAL DIRECTOR: Comon & McMullen	ADDRESS: Rising Sun Md.	25a. REC'D BY REGISTRAR DATE: MAR 3 1969	25b. REGISTRAR'S SIGNATURE: Florence Young	

VR A15(M)
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02289 02285

1. DECEASED-NAME (Type or print): First JOSEPH; Middle ALFRED; Last GODESKY

2a. DATE OF DEATH: February (Month) 5 (Day) 1969 (Year) 2b. HOUR: 3:35a M

3. SEX: Male

4. RACE: White

5. DATE OF BIRTH: May 31, 1919

6. AGE (In years last birthday): 49 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.

7a. BIRTHPLACE (State or foreign country): New Jersey

7b. CITIZEN OF WHAT COUNTRY? USA

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

9. COUNTY OF DEATH: Cecil Md.

10. CITY OR TOWN OF DEATH: Perry Point

11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Veterans Administration

12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Molder

12b. KIND OF BUSINESS OR INDUSTRY: Iron Fndry

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: New Jersey

13b. COUNTY: Hudson

13c. CITY OR TOWN: Bayonne

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET AND NUMBER: 52 Newman Avenue

14. FATHER'S NAME First Middle Last: Steven Godesky

15. MOTHER'S MAIDEN NAME First Middle Last: Mary Kotarski

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: Yes (If yes give war or dates of service): WWII

16b. SOCIAL SECURITY NO.: 144-07-4624

17. INFORMANT Address: VA Hospital Records, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia
485x
DUE TO, OR AS A CONSEQUENCE OF
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c):
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)

21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19

21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐

21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)

21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (X) (this hospital) attended the deceased from April 11, 1968, to Feb. 5, 1969, ~~that (I) (we) last saw the deceased alive on 19~~ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) ~~did not~~ view the body after death.

22b. SIGNATURE: Seymour Goldgraben DEGREE ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22c. DATE SIGNED: Feb. 5, 1969

22d. PHYSICIAN'S NAME (Type): SEMOUR GOLDGRABEN, M.D.

22e. ADDRESS: VA Hospital, Perry Point, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: Jan. 8, 1969

23c. NAME OF CEMETERY OR CREMATORY: ~~Holy Cross~~ Mt. Calvary

23d. LOCATION (City or Town) (County) (State): ~~North Arlington~~ LINDEN N.J.

24. FUNERAL DIRECTOR: Grant Funeral Home Paul R. Crouch ADDRESS Box 22 North East, Md.

25a. REC'D BY REGISTRAR DATE: FEB 6 1969

25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02290 02286

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

1. DECEASED-NAME (Type or print)	First: Marian	Middle: T.	Last: Godman	2a. DATE OF DEATH Month: 2 Day: 24 Year: 1969	2b. HOUR: 11:00 AM
3. SEX: Female	4. RACE: Cau.	5. DATE OF BIRTH: Dec. 22, 1894	6. AGE (In years last birthday): 74 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country): Kentucky	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Cecil Md.		
10. CITY OR TOWN OF DEATH: Carpenters Point	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): R.F.D.	12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.): House Wife	12b. KIND OF BUSINESS OR INDUSTRY: ----		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Cecil	13c. CITY OR TOWN: Pt. Carpenters	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET AND NUMBER: R.F.D.	
14. FATHER'S NAME First: James	Middle: H.	Last: Tinsley	15. MOTHER'S MAIDEN NAME First: Elizabeth	Middle:	Last: Pogue
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or Unknown: No (If yes give war or dates of service): ----	16b. SOCIAL SECURITY NO.: Unknown	17. INFORMANT: Marshall L. Godman	Address: Carpenters Point, Md.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Chronic Myocarditis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 4yr-
DUE TO, OR AS A CONSEQUENCE OF (b): Arthritis Deformans — 20yr
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 7130

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from Aug — 1968, to Feb 24 1969, that (I) (we) last saw the deceased alive on Feb 24 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE				22c. DATE SIGNED
Clarence I. Benson	M.D.	ATTENDING PHYS. [ ]	MED. DIRECTOR [X]	STAFF PHYS. [ ]	2/25/69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Clarence I. Benson M.D.	Box 123 - Port Deposit, Md

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town)	(County)	(State)
Burial	2/27/1969	Green Lawn Cemetery	Columbus		Ohio

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Lee A. Patterson & Son	Perryville, Md.	MAR 3 1969	Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02291 02287

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: BOOKER	Middle: T.	Last: HARPER	
2a. DATE OF DEATH	Month: 2	Day: 19	Year: 69	2b. HOUR: 10:55 am
3. SEX: Male	4. RACE: Negro	5. DATE OF BIRTH: 11-20-19	6. AGE (In years last birthday): 49 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country): Dew West, S.C.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Cecil Md.	
10. CITY OR TOWN OF DEATH: Perry Point	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Veterans Administration	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: District of Columbia	13b. COUNTY	13c. CITY OR TOWN: Washington	13d. INSIDE CITY LIMITS? YES [ ] NO [ ]	13e. STREET AND NUMBER: 450A Condon Terrace, SE
14. FATHER'S NAME First: John	Middle	Last: Booler (D)	15. MOTHER'S MAIDEN NAME First: Marie	Middle / Last: Harper
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): WW II	16b. SOCIAL SECURITY NO.: 254-42-4092	17. INFORMANT Address: VA Hospital Records, Perry Point, Md.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cerebral thrombosis acute.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4122

DUE TO, OR AS A CONSEQUENCE OF (b): Hypertensive cardiovascular disease.

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. **I certify** that (I) (this hospital) attended the deceased from Feb. 12, 19 69, to Feb. 19, 19 69 ~~xxxxxxxxx~~ that (I) (we) last saw the deceased alive ~~xxxxxxxxxxxxxxxxxxxxxxxxxxxx~~ 19~~xxx~~ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Irina Reus MD	DEGREE: ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [X]	22c. DATE SIGNED: 2-19-69	
22d. PHYSICIAN'S NAME (Type): IRINA REUS MD.	22e. ADDRESS: VA Hospital, Perry Point, Md.		

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE: 2/22/69	23c. NAME OF CEMETERY OR CREMATORY: Ware Shoal SC	23d. LOCATION (City or Town)	(County)	(State)
24. FUNERAL DIRECTOR: Hall Bros - HALL BROTHERS FUNERAL HOME	ADDRESS: 621 Fla. Ave. NW Wash D.C.	25a. REC'D BY REGISTRAR DATE: FEB 24 1969	25b. REGISTRAR'S SIGNATURE: [illegible] Judge		

VR A15 (4)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02292 Item 8 Film G09 2/10/69 kk

02288

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
	Walter	S.	HICKMAN	Feb. 12, 1969	12:50 M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.
Male	White	7-24-93	75 YRS.				

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Maryland	U.S.A.		Cecil Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street oddress)	12a. USUAL OCCUPATION (Kind of work done during most of warking life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Perry Point	VA Hospital	Farm & Various	Labor

13a. USUAL RESIDENCE (Where deceosed lived, if institutian: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Kent	Chestertown	YES ☒ NO ☐	619 W Cannt St.,

14. FATHER'S NAME First	Middle	Lost	15. MOTHER'S MAIDEN NAME First	Middle	Last
Stephen		Hickman (D)	Mary		Jewell (D)

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)	(If yes give wor or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
Yes	WW I	212-12-23-36	VA Hospital Records - Perry Point, Maryland	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral

DUE TO, OR AS A CONSEQUENCE OF

(b) Carcinoma of skin of right forehead with generalized metastasis

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

1723

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☒ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port I or Port 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that ☒ (this hospital) attended the deceased from 12-30-68, 19____, to 2-12-69, 19____, [illegible] and that in (my) (aur) apinian death accurred an the date and haur and from the causes stated abave, (I) (we) (did) (did nat) view the bady after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
A. L. Mooney, M.D.			☐	☒	2-12-69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
A. L. MOONEY, M.D.	VA Hospital - Perry Point, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	2/15/69	Chester Cemetery	Chestertown, Maryland

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Willis Wells WILLIS WELLS Funeral Home - Chestertown, Md.	FEB 17 1969	

VR A15 (4) 45M - 1-69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02293 02289

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (Rev.) 45M - 1-69

1. DECEASED-NAME (Type or print)	First: Ollie	Middle: Mae	Last: Ingram	2a. DATE OF DEATH Month: 2 Day: 22 Year: 1969	2b. HOUR: 4:05 P.M.	
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH: ~~Feb.~~ Jan. 17, 1924	6. AGE (In years last birthday): 45 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	
7a. BIRTHPLACE (State or foreign country): Shouns, Tenn.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Cecil Md.			
10. CITY OR TOWN OF DEATH: Elkton	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Union Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife	12b. KIND OF BUSINESS OR INDUSTRY: AT HOME			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.	13b. COUNTY: Cecil	13c. CITY OR TOWN: Elkton	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET AND NUMBER: 132½ Maffitt Street		
14. FATHER'S NAME First: Clifford	Middle:	Last: Willen	15. MOTHER'S MAIDEN NAME First: no information	Middle:	Last:	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: no (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 221-14-7275	17. INFORMANT Address: Ralph Ingram 132½ Maffitt St., Elkton, Md.				

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): CONGESTIVE HEART FAILURE — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 5 days

DUE TO, OR AS A CONSEQUENCE OF

(b): MYOCARDIAL INFARCTION — 3 days.

DUE TO, OR AS A CONSEQUENCE OF

(c): CORONARY THROMBOSES — 4 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. **I certify** that (I) (~~this~~ ~~corpse~~) attended the deceased from Feb. 13, 1969, to Feb. 22, 1969, that (I) (~~we~~) last saw the deceased alive on Feb. 22, 1969, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~xx~~ (did) (~~did not~~) view the body after death.

22b. SIGNATURE: Rolando A. Najera M.D.	DEGREE: ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]	22c. DATE SIGNED: 2/24/69	
22d. PHYSICIAN'S NAME (Type): Rolando A. Najera, M.D.	22e. ADDRESS: 105 E. Main St., Elkton, Md.		

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: Feb. 26, 1969	23c. NAME OF CEMETERY OR CREMATORY: Elkton Cemetery	23d. LOCATION (City or Town): Elkton	(County): Cecil	(State): Md.
24. FUNERAL DIRECTOR: PIPPIN FUNERAL HOME	ADDRESS: Elkton, Md.	25a. FILED BY REGISTRAR DATE: FEB 27 1969	25b. REGISTRAR'S SIGNATURE: [illegible]		

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02294 02290

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print): First: Adeline | Middle: Reba | Last: McCall

2a. DATE OF DEATH: Month: Feb. | Day: 22 | Year: 1969

2b. HOUR: 5:35 A.M.

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH: Oct. 12, 1889

6. AGE (In years last birthday): 79 YRS. | IF UNDER 1 YEAR: MONTHS, DAYS | IF UNDER 24 HRS.: HOURS, MIN.

7a. BIRTHPLACE (State or foreign country): Maryland

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9. COUNTY OF DEATH: Cecil Md.

10. CITY OR TOWN OF DEATH: North East

11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street oddress): R.D. # 2

12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Homemaker

12b. KIND OF BUSINESS OR INDUSTRY: Home

13a. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) STATE: Maryland

13b. COUNTY: Cecil

13c. CITY OR TOWN: Charlestown

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET AND NUMBER:

14. FATHER'S NAME: First: Lewis | Middle: A. | Last: McCall

15. MOTHER'S MAIDEN NAME: First: Carrie | Middle: | Last: Clark

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16b. SOCIAL SECURITY NO.: 215-56-1241

17. INFORMANT: Nellie V. McCall | Address: Charlestown, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardio Vascular Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 30 min.

4122

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

DUE TO, OR AS A CONSEQUENCE OF (b): C.V.A. - Cerebral Hemorrhage — 4 wks.

DUE TO, OR AS A CONSEQUENCE OF (c): Hypertension- H.C.V.D. — years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

G.A.S.C. - A.S.C.V.D., Fractured Hip, Large Bed Sores.

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol exominer)

21b. TIME OF INJURY: HOUR A.M. P.M. Month Day Year 19

21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)

21d. INJURY OCCURRED While ot work ☐ Not while ot work ☐

21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)

21f. LOCATION Street or R.F.D. No. City or Town County Stote

22a. **I certify** that (I) (this hospital) attended the deceased from Jan. 8, 1969, to Feb. 22, 1969, that (I) (we) last saw the deceased alive on Feb. 21, 1969, and that in (my) (our) opinion death occurred on the date and haur and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Luis Cuza MD — DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22c. DATE SIGNED: Feb. 24, 1969

22d. PHYSICIAN'S NAME (Type): Luis M. Cuza M.D.

22e. ADDRESS: 322 E. Cecil Ave. North East, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 2-26-69

23c. NAME OF CEMETERY OR CREMATORY: North East Methodist

23d. LOCATION (City or Town) (County) (State): North East Cecil Md.

24. FUNERAL DIRECTOR: Grant Funeral Home — ADDRESS: Box 22 North East, Md. — Paul A. Crouch

25a. REC'D BY REGISTRAR (DATE): FEB 26 1969

25b. REGISTRAR'S SIGNATURE: Clarence Savage

VR A15 (4) 45M - 1-69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02295 — 02291

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

1. DECEASED-NAME (Type or print)	First: Arthur	Middle: D.	Last: Moon	2a. DATE OF DEATH Month: Feb	Day: 8	Year: 1969
2b. HOUR: 6 P M						
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: Mar. 10, 1883	6. AGE (In years last birthday): 85 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	
7a. BIRTHPLACE (State or foreign country): Md.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: Cecil Md.			
10. CITY OR TOWN OF DEATH: Elkton	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Union Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Engineer	12b. KIND OF BUSINESS OR INDUSTRY: Railroad			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.	13b. COUNTY: Cecil	13c. CITY OR TOWN: North East	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 108 E. Cecil Ave.		
14. FATHER'S NAME First: John	Middle: H.	Last: Moon	15. MOTHER'S MAIDEN NAME First: Clara	Middle: A.	Last: Lake	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown): No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 716-12-3092	17. INFORMANT: Elizabeth B. McMullen	Address: Charlestown, Md.			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Acute myocardial infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO, OR AS A CONSEQUENCE OF

(b): Arteriosclerotic cardiovascular disease — 5 yrs.

DUE TO, OR AS A CONSEQUENCE OF

(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)		
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County / State

22a. I **certify** that (I) (this hospital) attended the deceased from 1-8, 19 63, to 2-8, 19 69, that (I) (we) last saw the deceased alive on 2-8 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Jay S. Baumhart Jr.	DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED: 2-10-69		
22d. PHYSICIAN'S NAME (Type): Jay S. Baumhart Jr.	22e. ADDRESS: 4 Maulden Ave North East, Md.			

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 2-12-69	23c. NAME OF CEMETERY OR CREMATORY: Cathedral Cemetery	23d. LOCATION (City or Town) (County) (State): Wilmington, New Castle Del.	
24. FUNERAL DIRECTOR: Paul R Crouch	ADDRESS: Grant Funeral Home North East, Md	25a. REC'D BY REGISTRAR DATE: FEB 13 1969	25b. REGISTRAR'S SIGNATURE: J Charles Judge	

Item 18 Film 409 2-18

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02296 — 02292

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health priar to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print) First	Middle	Lost	2o. DATE KNOWN OF DEATH ESTIMATED	Month	Doy	Yeor	2b. HOUR
HARRY	SHELTON	OSBORNE	X	2	11	1969	5:35p

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	IF UNDER 1 YEAR: MONTHS	DAYS	IF UNDER 24 HRS.: HOURS	MIN.	2c. DATE PRONOUNCED DEAD Month	Doy	Yeor	2d. HOUR
Male	White	Jan.27,1914	55 YRS.					February	11,	1969	5:35 PM

7o. BIRTHPLACE (Stote or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Tennessee	U.S.A.		Cecil Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street oddress)	12o. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Elkton	Union Hospital	Carpenter	Building

13o. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☐ NO XX	13e. STREET AND NUMBER
Md.	Cecil	Elkton		R. D. 4, Andora

14. FATHER'S NAME First	Middle	Lost	15. MOTHER'S MAIDEN NAME First	Middle	Lost
Henson	Osborne		Inez		Shupe

16o. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	232-18-1745	Mrs. Ella Mae Osborne, Elkton, Md.	R.D. # 4

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o) Fatty liver Acute alcoholism — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
303.9
Conditions, if ony, which gove rise to immediote couse (o), stoting the underlying couse lost.
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(o)

19o. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES XX NO ☐

21o. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Doy, Yeor HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, form, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	Stote

22a. **I certify** that I taak charge af the remains described abave, held an Autapsy XX Inspectian ☐, Inquiry ☐, and in my apinian death resulted from: Natural causes XX, Accident ☐, Suicide ☐, Hamicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Edward F. Wilson M.D.

EXAMINER'S NAME (Type) Edward F. Wilson, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER XX
DEPUTY MEDICAL EXAMINER ☐
ADDRESS(Street, city, town, or county)

22b. DATE SIGNED 2/12/69

23o. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (Stote)
Burial	2/15/69	Gilpin Manor Memorial Park,	Elkton, Md.

24. FUNERAL DIRECTOR ADDRESS	DATE	25b. REGISTRAR'S SIGNATURE
Ralph E. Hicks Hicks Home for Funerals, Elkton, Md.	FEB 18 1969	

VR A15ME (5) 10M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02297 · 02293

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

1. DECEASED-NAME (Type or print)	First: Arthur	Middle: S.	Last: REISHER	2a. DATE OF DEATH: Month February Day 7, Year 1969	2b. HOUR: M	
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: 5-31-96	6. AGE (In years lost birthday): 72 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.	
7a. BIRTHPLACE (State or foreign country): Penna.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9. COUNTY OF DEATH: Cecil Md.			
10. CITY OR TOWN OF DEATH: Perry Point	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): VA Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Shoemaker	12b. KIND OF BUSINESS OR INDUSTRY: Shoemaking			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Washington	13c. CITY OR TOWN: Hagerstown	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 719 George St.,		
14. FATHER'S NAME First / Middle / Last		15. MOTHER'S MAIDEN NAME First / Middle / Last				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: Yes	(If yes give war or dates of service): WW I	16b. SOCIAL SECURITY NO.: 214-09-57-81	17. INFORMANT Address: VA Hospital Records - Perry Point, Maryland			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Bronchopneumonia, bilateral — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

4339

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): C. V. A. (Cerebral infarction) — 2 months

DUE TO, OR AS A CONSEQUENCE OF (c): Cerebral arteriosclerosis

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☒ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, natify medicol exominer)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State

22a. **I certify** thot (I) (this hospital) attended the deceased from 5-3-61, 19____, to 2-7-69, 19____, that (I) (we) last saw the deceased alive on ~~XXXXXXXXXXXXXXXX~~ 19____, and thot in (my) (our) opinion deoth occurred on the dote ond haur and from the causes stated above, (I) (we) (did) (did nat) view the body after deoth.

22b. SIGNATURE	DEGREE: ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒	22c. DATE SIGNED
A. L. Mooney, M.D.		2-7-69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
A. L. MOONEY, M.D.	VA Hospital - Perry Point, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	2/10/69	Cedar Grove Cemetery	Chambersburg, Penna

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Lee A. Patterson & Son, Perryville, Md.	FEB 14 1969	Registrar Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02298 02294

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
John	L.	Ryan	Feb 9 1969	M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
Male	Cau	March 15, 1898	70 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
Delaware	U.S.A.	WIDOWED [X]	Cecil Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Elkton	Union Hospital	Retired	Carpenter

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Cecil	Charlestown	YES [X] NO [ ]	

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Frank	B.	Ryan	Kate	B.	Jackson

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
No	---	218-03-9833	J. O. Ryan, Perryville, Maryland.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardio-Vascular Failure	30 Minutes
1621 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b)	Mediastinal & Lung Metastasis	1 year
DUE TO, OR AS A CONSEQUENCE OF (c)	Bronchogenic Carcinoma	2 years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Osteo Arthritis - deformant

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES [X] NO [ ]	Yes

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 9-24, 1954 to 2-9, 1969, that (I) (we) last saw the deceased alive on 2-8-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Luis M. Cuza MD	MD	[X]	[ ]	[ ]	2-11-69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
LUIS M. CUZA, M.D.	322 E. Cecil Ave. North East, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	2/11/1969	North East Cemetery	North East Cecil Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Lee A. Patterson & Son, Perryville, Md.	FEB 14 1969	J. Charles Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 4M 45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

02281

Male | Cecil | March 15, 1898 | 70

Delaware | U.S.A. | Cecil

Elkton | Union Hospital | Elkton

Maryland | Cecil | Charlestown

Frank | Ryan | Jackson

220-15-2053 | J. C. Ryan, Perryville, Maryland

Lung cancer

2-11-69 | Cecil | North East, Md.

Burial | 2/14/1969 | North East Cemetery | North East, Cecil, Md.

R. T. Richardson & Son, Perryville, Md.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02299

CERTIFICATE OF DEATH

02295

1. DECEASED-NAME (Type or print) First: Joseph	Middle: GIFFORD	Last: SCARBOROUGH	2a. DATE OF DEATH Month: February	Day: 20	Year: 1969	2b. HOUR: 4:48 P M
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: 7-5-11	6. AGE (In years last birthday): 57 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN	
7a. BIRTHPLACE (State or foreign country): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [XX] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Cecil Md.			
10. CITY OR TOWN OF DEATH: Perry Point	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): VA Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Lawyer	12b. KIND OF BUSINESS OR INDUSTRY: Law			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Cecil	13c. CITY OR TOWN: Elkton	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET AND NUMBER: 200 Kentmere Ave.,		
14. FATHER'S NAME First: J. LEEDOM	Middle	Last: Scarborough	15. MOTHER'S MAIDEN NAME First: Nelly	Middle	Last: Kerr	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown): Yes	(If yes give war or dates of service): WW II	16b. SOCIAL SECURITY NO.: 213-12-54-34	17. INFORMANT Address: VA Hospital Records - Perry Point, Maryland			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Cardiac Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden
4109
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Artery Occlusion, severe
DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Heart Disease with severe sclerosis of Coronary Arteries

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Diabetes Mellitus

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [XX] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 7-10-68, 19____, to 2-20-69, 19____ ~~saw the deceased alive on~~, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
A.L. Mooney, M.D.		[ ]	[ ]	[X]	Feb. 20, 1969

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
A. L. MOONEY, M.D.	VA Hospital - Perry Point, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	2/24/69	FRIENDS CEMETERY	CALVERT CECIL Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Pippin Funeral Home	Pippin Funeral Home, Elkton, Md.	FEB 24 1969	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

10 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of the death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02300 02296

1. DECEASED-NAME (Type or print) First: Merle	Middle: W.	Lost: Simpers	2a. DATE OF DEATH Month: Feb. Day: 21 Year: 1969	2b. HOUR: 4:00 PM	
3. SEX: male	4. RACE: White	5. DATE OF BIRTH: 6/7/05	6. AGE (In years last birthday): 63-64 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Cecil County Md.		
10. CITY OR TOWN OF DEATH: Elkton	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): Union Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Mail Clerk	12b. KIND OF BUSINESS OR INDUSTRY: Civil Service		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Cecil	13c. CITY OR TOWN: North East	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET AND NUMBER: 407 S. Maryland Ave.	
14. FATHER'S NAME First: Harry	Middle:	Lost: Simpers	15. MOTHER'S MAIDEN NAME First: Mary	Middle:	Lost: Devore
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No	16b. SOCIAL SECURITY NO.: 188-05-1346	17. INFORMANT: Mrs. Bess F. Simpers	Address: 407 S. Md. Ave. North East, Md.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) METASTATIC ADENOCARCINOMA OF Colon — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 11 YEARS
DUE TO, OR AS A CONSEQUENCE OF
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediote couse (a), stating the underlying couse last. 1538

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medicol exominer)	21b. TIME OF INJURY HOUR A.M. P.M. Month Doy Yeor 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)		
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County / Stote

22a. **I certify** that (I) ~~(this hospital)~~ attended the deceased from 8 OCT, 19 68, to present, 19____, that (I) ~~(last)~~ saw the deceased alive on 20 Feb, 1969, and that in (my) (~~our~~) opinian death accurred on the date and hour and from the causes stated abave, (I) (~~we~~) (~~did~~ did nat) view the bady after death.

22b. SIGNATURE: Robert L. Gray	MD DEGREE	ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]	22c. DATE SIGNED: 21 Feb 1969.	
22d. PHYSICIAN'S NAME (Type): Robert L. Gray	22e. ADDRESS: 123 W. High St. Elkton, Md.			

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 2-25-29	23c. NAME OF CEMETERY OR CREMATORY: St. Mary Anne's	23d. LOCATION (City or Town) (County) (State): North East Cecil Md.	
24. FUNERAL DIRECTOR: Grant Funeral Home Paul R. Couch	ADDRESS: Box 22 North East, Md.	25a. REC'D BY REGISTRAR DATE: FEB 25 1969	25b. REGISTRAR'S SIGNATURE: Charles Judge	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02301 — 02297

1. DECEASED-NAME (Type or print): First: Lily; Middle: B.; Last: Slade
2a. DATE OF DEATH: Month: February; Day: 10; Year: 1969
2b. HOUR: M
3. SEX: Female
4. RACE: White
5. DATE OF BIRTH: May 12, 1893
6. AGE (In years last birthday): 75 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (State or foreign country): England
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. COUNTY OF DEATH: Cecil Md.
10. CITY OR TOWN OF DEATH: Elkton
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Union Hospital
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife
12b. KIND OF BUSINESS OR INDUSTRY: --
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland
13b. COUNTY: Cecil
13c. CITY OR TOWN: Elkton
13d. INSIDE CITY LIMITS? YES ☐ NO ☒
13e. STREET AND NUMBER: Box 218, R.D. # 3
14. FATHER'S NAME: First: Absolm; Middle: ; Last: Joyce
15. MOTHER'S MAIDEN NAME: First: Louisa; Middle: Jane; Last: Beaton
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service)
16b. SOCIAL SECURITY NO.:
17. INFORMANT: Address: R.D.# 3 Leonard F. Slade, Elkton, Md. 21921

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ACUTE ANTERIOR MYOCARDIAL INFARCTION
DUE TO, OR AS A CONSEQUENCE OF
(b): ASCVD
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
DIABETES MELLITUS

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES ☒ NO ☐
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (~~this hospital~~) attended the deceased from _____, 1967, to Present, 19____, that (I) (~~saw~~) last saw the deceased alive on 10 Feb 1969, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~saw~~) (~~did~~) (did not) view the body after death.

22b. SIGNATURE: Robert L. Gray M.D. DEGREE — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. DATE SIGNED: 14 Feb 1969
22d. PHYSICIAN'S NAME (Type): Robert L. Gray
22e. ADDRESS: 123 W. High St. Elkton, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 2/14/69
23c. NAME OF CEMETERY OR CREMATORY: Gracelawn Memorial Park, Wilmington, Del.
23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR: Ralph E. Hicks
ADDRESS: Hicks Home for Funerals, Elkton, Md.
25a. REC'D BY REGISTRAR DATE: FEB 18
25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02302 — 02298

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: JOHN	Middle: Wesley	Last: SMITH	2a. DATE OF DEATH Month: 2 Day: 27 Year: 69	2b. HOUR: 10:10 AM	
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: 10-16-07	6. AGE (In years last birthday): 61 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	
7a. BIRTHPLACE (State or foreign country): Virginia	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: Cecil Md.			
10. CITY OR TOWN OF DEATH: Perry Point	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Veterans Administration	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Mechanic	12b. KIND OF BUSINESS OR INDUSTRY: auto			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Harford	13c. CITY OR TOWN: Edgewood	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET AND NUMBER: 503 Kennard Avenue		
14. FATHER'S NAME First: John Henry	Middle	Last: Smith (D)	15. MOTHER'S MAIDEN NAME First: Alice	Middle: Dyer (D)	Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: Yes	(If yes give war or dates of service): WW II	16b. SOCIAL SECURITY NO.: 226-72-2409	17. INFORMANT Address: VA Hospital Records, Perry Point, Md.			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Bronchopneumonia, bilateral

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last. 492X

DUE TO, OR AS A CONSEQUENCE OF (b): Pulmonary emphysema with right side heart failure (Cor pulmonale).

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☒ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / Stote	

22a. **I certify** that (I) (this hospitol) attended the deceased from Feb. 21, 19 69, to Feb. 27, 19 69, ~~that (I) (we) last saw the deceased alive on xxxxxxxxxxxxxxxx 19xxx~~ and that in (my) (aur) opinian death occurred on the date and haur and from the couses stated abave, (I) (we) (did) (did nat) view the body after death.

22b. SIGNATURE: A. L. Mooney M.D. DEGREE	ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒	22c. DATE SIGNED: 2-27-69	
22d. PHYSICIAN'S NAME (Type): A. L. Mooney, M.D.	22e. ADDRESS: VA Hospital, Perry Point, Md.		

23a. BURIAL, CREMATION, REMOVAL (Specify): ~~Removal~~ Burial ~~Burial~~	23b. DATE: 3-3-69	23c. NAME OF CEMETERY OR CREMATORY: Baltimore National Cemetery	23d. LOCATION (City or Town): Baltimore	(County) (State): Md.
24. FUNERAL DIRECTOR: McCOMAS Funeral Home	ADDRESS: Abington, Md.	25a. REC'D BY REGISTRAR DATE: MAR 3 1969	25b. REGISTRAR'S SIGNATURE	

VR A15 (4) 45M - 1/69

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
1DM REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH

02303

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02299

1. DECEASED-NAME (Type or Print) First: Theresa	Middle: E.	Last: Starliper	2a. DATE OF DEATH: KNOWN [X] ESTIMATED [ ] Month: Feb. Day: 8 Year: 1969	2b. HOUR: M		
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH: Mar. 1, 1902	6. AGE (In years last birthday): 66 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	2c. DATE PRONOUNCED DEAD: Month: Feb. Day: 8 Year: 1969	2d. HOUR: 2:20 P.M.	
7a. BIRTHPLACE (State or foreign country): Penna.	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Cecil Md.			
10. CITY OR TOWN OF DEATH: Elkton	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Union Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife	12b. KIND OF BUSINESS OR INDUSTRY: Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Penna.	13b. COUNTY: Delaware	13c. CITY OR TOWN: Morton	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET AND NUMBER: 409 Highland Ave.		
14. FATHER'S NAME First: John	Middle:	Last: Eberwine	15. MOTHER'S MAIDEN NAME First: Unknown	Middle:	Last:	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 204-07-6408	17. INFORMANT: William D. Starliper	ADDRESS: Morton, Penna.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	MYOCARDIAL INFARCTION	
DUE TO, OR AS A CONSEQUENCE OF (b)	CORONARY THROMBOSES	20-30 min.
DUE TO, OR AS A CONSEQUENCE OF (c)	ARTERIOSCLEROTIC CARDIOVASCULAR DIS.	4 years.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES [ ] NO [X]

21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. **I certify** that I took charge of the remains described above, held an Autopsy [ ], Inspection [ ], Inquiry [ ], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Rolandd A. Najera Jr. M.D.

EXAMINER'S NAME (Type): Rolando A. Najera, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [ ]
ADDRESS(Street, city, town, or county)

22b. DATE SIGNED: Feb. 8, 1969

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: Feb. 12, 1969	23c. NAME OF CEMETERY OR CREMATORY: St. Peter & Paul	23d. LOCATION (City or Town) (County) (State): Springfield Delaware Penna.	
24. FUNERAL DIRECTOR: Grant Funeral Home Paul R. Crouch	ADDRESS: North East, Md.	25a. REC'D BY REGISTRAR DATE: FEB 11 1969	25b. REGISTRAR'S SIGNATURE:	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02304

CERTIFICATE OF DEATH

02300

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar ta burial, cremation, ar removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. **PLACE OF DEATH**
   a. COUNTY: CECIL — MARYLAND
   b. CITY OR TOWN (If outside corporote limits, write RURAL ond give neorest town): RISING SUN
   c. LENGTH OF STAY IN 1b: 10 YRS
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress)

2. **USUAL RESIDENCE** (Where deceosed lived, if institution: Residence before admission)
   a. STATE: MARYLAND — b. COUNTY: CECIL
   c. CITY OR TOWN (If outside corporote limits, write RURAL ond give neorest town): RISING SUN (RURAL)
   d. STREET ADDRESS
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First WINIFRED — Middle PUGH — Lost STUART

4. **DATE OF DEATH**: Month FEB. — Doy 13 — Year 1969

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: JAN. 15, 1893

9. AGE (In yeors last birthday): 76 yrs.

IF UNDER 1 YEAR: Months — Doys

IF UNDER 24 HRS.: Hours — Min.

10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: HOME

11. BIRTHPLACE (County & State, or foreign country): VERGINIA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WILLIAM R. PUGH

14. MOTHER'S MAIDEN NAME: ELEANOR MOORE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give wor or dotes of service)

16. SOCIAL SECURITY NO.: 219-10-3139

17. **INFORMANT** Address: MRS JAMES LAWSON JR. RISING SUN, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO (b): Arteriosclerotic heart disease — 5 yrs.
DUE TO (c):
Conditions, if ony, which gove rise to immediote couse (o), stoting the underlying couse lost. 4109

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20o. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19

20d. INJURY OCCURRED While ot work ☐ Not While ot work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** thot (I) (this hospital) ottended the deceased from 6-1, 1969, to 2-13, 1969, that (I) (we) last saw the deceased alive on 2-12 1969, and that death accurred at 9A M, from causes and on the date stated above.

22o. SIGNATURE: Neil R Taylor — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2-13-69

22c. PHYSICIAN'S NAME (Type): Neil R Taylor Jr

22d. ADDRESS

23o. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: FEB. 16, 1969

23c. NAME OF CEMETERY OR CREMATORY: BROOKVIEW

23d. LOCATION (City or Town) (County) (State): RISING SUN, CECIL, MD

24. FUNERAL DIRECTOR: Ralph M. Reed — ADDRESS: RISING SUN, MD.

25o. REC'D BY REGISTRAR DATE: FEB 17 1969

25b. REGISTRAR'S SIGNATURE

1

02305

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02301

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
Josephine	E.	Wardell	Feb.	8	1969	4:18 A.M.

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS	DAYS	IF UNDER 24 HRS.: HOURS	MIN.
Female	White	Oct. 12, 1892	76 YRS.				

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
Delaware	USA		Cecil Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Elkton	Union Hospital	Housewife	Home

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Cecil	North East	YES ☒ NO ☐	215 S. Main St.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Harry	C.	Milbourne	Sophia		Payne

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
No			Harry T. Milbourne	4200 Verona Dr. Wilmington 8, Del.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) METASTATIC ADENOCARCINOMA BREAST — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 years.

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 174 X

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (~~this hospital~~) attended the deceased from _____, 1963, to Present, 19____, that (I) (~~me~~) last saw the deceased alive on 7 Feb 1969, and that in (my) (~~my~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~was~~) (~~did~~) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Robert L. Gray	M.D	☒	☐	☐	10 Feb 1969

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Robert L. Gray	123 W. High St. Elkton, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town)	(County)	(State)
Burial	Feb. 11, 1969	St. Barnabas	Marshallton	New Castle	Del.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Grant Funeral Home Paul K. Grant	Box 22 North East, Md.	FEB 13 1969	J. Charles Jones

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45M - 1/69

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

02306 02302 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Cecil MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Cecil

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Warwick

c. LENGTH OF STAY IN 1b

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Warwick

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

d. STREET ADDRESS

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

00 07 1

3. NAME OF DECEASED (Type or print) First: Emma Middle: P. Last: Williams

4. DATE OF DEATH Month: Feb Day: 1 Year: 1969

5. SEX: Female

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Mar 4, 1891

9. AGE (In years last birthday) 77 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Pope

14. MOTHER'S MAIDEN NAME: Rose Hoover

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Address: Walter Williams - Warwick, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Embolism — INTERVAL BETWEEN ONSET AND DEATH: 1day

4100

DUE TO (b) Coronary Artery Disease — 2 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c) Chronic Hypertention — 11 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

2

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan. 15, 1957 to Feb. 1, 1969, that I last saw the deceased alive on Feb. 1, 1969, and that death occurred at 3:45P M, from the causes and on the date stated above.

ACTUAL SIGNATURE Allan R. Cruchley M.D.

ADDRESS (Street, city or town, state)

DATE SIGNED 2-4-69

PHYSICIAN'S NAME (Type) Allan R. Cruchley, M.D.

1

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: Feb 5, 1969

22c. NAME OF CEMETERY OR CREMATORY: Old Bohemia Cem.

22d. LOCATION (City, town, or county) (State): Warwick - Md.

23. FUNERAL DIRECTOR'S SIGNATURE: J. Lester Dandy - ADDRESS: Middletown, Del.

24a. REC'D BY REGISTRAR DATE: FEB 7 1969

24b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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15M 9/55